



**DEPARTMENT OF SOCIAL SERVICES**  
**DIVISION OF MEDICAL SERVICES**  
 700 Governors Drive  
 Pierre, South Dakota 57501-2291  
 (605) 773-3495  
 Fax: (605) 773-5246  
 medical@state.sd.us

DATE: \_\_\_\_\_

### GENERAL PRIOR AUTHORIZATION REQUEST FORM

Please Check box:

**Hospital**

- ☐ Long Term Care  
     Hospital  
☐ NICU  
☐ Psychiatric  
☐ Rehabilitation  
☐ Specialty

**Physician**

- ☐ Medical Surgical

**Psychological**

- ☐ Inpatient  
     Psychiatric Facility  
☐ Residential

**Home Care Services**

- ☐ Private Duty Nursing  
☐ Durable Medical Equipment  
☐ Extended Home Health Aide  
☐ Medication  
☐ Nutrition

☐ **EPSDT**

☐ **Other**

First date of service \_\_\_\_\_

Last date of service \_\_\_\_\_

#### GENERAL INFORMATION

Recipient. Number—9 digits	Last Name	First Name	Date of Birth
			Sex:
Diagnosis Code	Procedure Code	Procedure Description	Quantity

**EXPLANATION OF NECESSITY FOR PROCEDURES** (Attach supporting x-rays, lab reports, operative reports, and discharge summaries etc. if indicated)

#### PROVIDER INFORMATION

Medical Assistance Provider Number _____
I certify that the information given in this form is a true and accurate medical indication for the procedures required. All other treatment to correct this problem has been exhausted.
<div style="display: flex; justify-content: space-between;"> <div>_____ Provider Signature</div> <div>_____ Date</div> </div>
Provider Name: _____
Address: _____ _____
Provider Phone # _____ Fax # _____ E-Mail _____